ATTACHMENT XI

STATE OF CALIFORNIA
EMERGENCY MEDICAL SERVICES AUTHORITY
1999 STATEWIDE Y2K HOSPITAL READINESS EXERCISE

AMBULANCE AVAILABILITY FORM

*** This form should reflect ambulance status as of 0800 hrs. on September 16, 1999 ***

Please complete the form and fax it to the designated county representative/agency from 0830 to 0900 hrs.

1 Name of Provider:_____

Address:_____ 2 City:_____ Zip:_____

3 Key Contact for Disaster Planning:_____ 4 Telephone #:_____

FAX:_____ 5 email:_____ County:_____

6 Ambulance Provider State License #: _____

As of: 0800 hrs. On: Sept. 16, 1999	Number of Licensed Ambulances Owned (A)	Number of Fully Staffed and EquippedAmbulances Available to Respond to Calls at 0800 Hours (B)	Additional Number of Fully Staffed and Equipped Ambulances That You Can Have Available in 2 Hours for Disaster or Mutual Aid Response (C)
Basic Life Support 7			
Advanced Life Support 8			
TOTAL 9			

AMBULANCE PROVIDER SERVICE STATUS (Please circle one):

10 **Green** **Yellow** **Red** **Black**

"Green":	Provider is able to carry out normal operational functions.
"Yellow":	Some reductions in patient services, but overall, provider is able to carry out normal operational functions.
"Red":	Significant reductions in patient services. Emergency services only being provided.
"Black":	Provider has been severely affected. Unable to continue any services.